BRIEF OF EVIDENCE FOR THE MINISTERIAL INQUIRY INTO THE UNDER-REPORTING OF CERVICAL SMEAR ABNORMALITIES IN THE GISBORNE REGION

Dr Gerard V. Wain

INTRODUCTION

1. My name is Gerard Vincent Wain. I am currently the Director of Gynaecological Oncology at Westmead Hospital in Sydney and a Senior Lecturer in Gynaecological Oncology at the University of Sydney. I am a gynaecological oncologist and hold the Certificate of Gynaecological Oncology (CGO) of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). I have been involved in the clinical management of patients with a range of gynaecological cancers including cervical cancer since commencing specialist gynaecological oncology practice approximately 12 years ago.

2. I am also currently the Director of the New South Wales Cervical Screening Program (NSW CSP). This position involves administrative responsibility for the coordination of cervical screening activities in the state of NSW. The position also gives me a broad awareness of and involvement in cervical screening activities in the rest of Australia.

3. A detailed curriculum vitae is attached in Appendix 1.

SCOPE OF THE EVIDENCE

4. I have been asked to give evidence to this inquiry on two aspects, the first related to my clinical experience as a gynaecological oncologist and the second related to my role as director of the NSW CSP.

5. Firstly, I have been asked to review the patient files and records on patients 1-9 with a view to commenting on their experience with the screening program, their clinical management and outcome and to comment on any of the clinical issues raised. I have also reviewed the briefs of evidence of a further 10 women (patients 11-20), although I have not seen nor reviewed their detailed clinical records.

6. Secondly, I have been asked to give some general information about the conduct of cervical screening in Australia, including the introduction and implementation of quality standards in

Australia, particularly in relation to laboratory reporting.

7. In relation to aspects of the New Zealand screening program or some of the clinical management, my limited appreciation of the New Zealand health system means that I am not in a position to make direct comparisons between the Australian or New Zealand systems. My clinical comments relate however to general principles of management, which I think should be valid for any country.

REVIEW OF CASE FILES

8. In order to carry out this review, I have:

- Read the statements of evidence supplied to this inquiry by patients 1-9, as well as their transcripts of examination, and

- Read all of the patient files that have been provided to me by counsel assisting the inquiry.

1. In the evidence that follows and in framing my observations, I have made the following general assumptions:

a) The materials I have reviewed are a complete record of the clinical events that have taken place. Obviously I was not a party to any of the discussions that were recorded in the notes and cannot be aware of any conversations that may have taken place, but were not included or recorded in the notes. I cannot be aware of any other relevant information that is not recorded. I note that not all of the files are chronologically complete (one file has a gap of five years). My comments therefore need to be interpreted against this background.

b) I have proceeded on the assumption that the re-read of the slides by the Sydney laboratory is "correct", by which I mean that the Sydney report is the one that should have been issued at the time by Dr Bottrill. I am not a pathologist and obviously have not reviewed any of the slides myself.

1. For each case, I have prepared a chronology, which I have collated and abstracted from all of the information sources available. I have either summarised or expanded abbreviations where these are obvious or in common medical usage or quoted directly from portions of the record. I have deliberately excluded those aspects of the record that I have judged to be irrelevant, for example, episodes of care for completely unrelated medical problems. Despite these exclusions and given the constraints of reviewing less than complete medical records from a variety of sources, I have tried to faithfully reproduce enough of the relevant material to give a sense of the clinical

circumstances.

2. I have taken the information about the Sydney “re-read” from the summaries in the patient’s evidence, as copies of the Sydney re-reads have not been consistently included in the patient files.

3. At the end of each chronology, I have offered some general comments about each case, based on my interpretation of the events.

4. I also wish to preface my comments with a general comment that applies to all of the cases. In a number of circumstances, I have made reference to the consequences suffered by the women as a result of the apparent mis-reading of their smears. I have limited my comments strictly to the medical consequences of any delay. Undoubtedly the delays and the subsequent discovery of the mis-reading will have caused significant anxiety, suffering and hardship, and these stories are graphically illustrated in the patient’s own evidence. I acknowledge the anxiety is real and likely to have been significant, but have made no effort to quantify the extent of this anxiety, to estimate it for any particular woman or to include it as a consequence of the delay.

GENERAL OBSERVATIONS ABOUT EACH CASE

13. PATIENT 1:

This patient obviously underwent regular screening over several years, with a total of six smears in the 6 years prior to diagnosis (excluding the smear taken immediately prior to diagnosis). All smears were reported as essentially normal until presentation with obvious cervical cancer. There is no information in the clinical records about who took smears or whether the cervix was examined. There were no apparent abnormal gynaecological symptoms recorded until approximately the time of diagnosis, or just immediately prior to that.

Although it is not normal practice in Australia, it would have been helpful in retrospect to have had some documentation of the appearance of the cervix at the time of taking the smear.

It seems likely that failure to recognise her smears as abnormal has lead to a delay in diagnosis, progression to advanced disease and the need for radical treatment.

I note that smears on 17 Oct 88, 26 Oct 89 and 12 Sep 91 (all reported by Medlab Hamilton) do not seem to have been reviewed. A re-read of these smears may be helpful in establishing whether any lesion was present throughout this time.

PATIENT 2: This patient presented with common gynaecological problems related to

IUCD and menorrhagia. She had a “normal” smear in February 1991 reported by Dr Bottrill (on Sydney re-read this was a “high grade” smear). A smear reported by Dr Bottrill as “low grade” in Feb 92 was not assessed by colposcopy at the time. This smear was “high-grade “ on the Sydney re-read. Instead she underwent a repeat smear which was reported as normal (which was also reported as “high-grade” on Sydney re-read) and therefore had no further investigations. A further inflammatory smear in April 1993 and then a “high-grade” precipitated eventual assessment and diagnosis of her disease. Both of these smears were “high-grade” on the Sydney re-read.

She was eventually found to have CIN 3 plus adenocarcinoma-in-situ in April 93 and underwent relatively routine treatment, although unfortunately this was complicated by secondary haemorrhage which in itself is not unusual. Subsequent smears have been normal and there appears to been no apparent consequence from the delay in diagnosis. Her dramatic symptoms were more related to her other gynaecological problems than to her preinvasive disease of the cervix.

Had the diagnosis of CIN been made any earlier, the treatment would have been the same, with the same risk of complications such as secondary haemorrhage.

The patient appeared surprised at the progression from normal to CIN 3, but this is not an unusual clinical event. The evidence brief and cross examination both suggest that patient had a lack of information and understanding of difference between CIN and invasive cancer. The patient was under the impression that she had an aggressive form of cancer due to apparent rapid progression, which is not supported by the presence of multiple prior abnormal smears.

PATIENT 3:

This patient remained asymptomatic throughout and had preinvasive disease at the time of eventual diagnosis. Her CIN was eventually picked up with no significant clinical consequences from the delay in diagnosis. There was no significant progression of disease in the time interval from her original low grade/inconclusive abnormal smears in 1991 and 1992 to 1997 (although there is a gap in her clinical records during this time). The Sydney re-read of the 1991 smear was of “abnormal squamous cells – high grade cannot be excluded” and of the 1992 smear was “low-grade epithelial abnormality – CIN 1”.

The patient’s supposition that the second LLETZ was required because of delay is not

necessarily the case. It is not uncommon to require a second LLETZ procedure, especially when the first has positive margins.

PATIENT 4:

This patient had several routine smears, which failed to detect any abnormality. Two of these smears (8 Jan 92 and 27 Apr 95) were reported as normal by Dr Bottrill and copies of the report are included in the notes. Both of these were reported as “high-grade” on the Sydney re-read. Two other smears (13 Apr 89 and 16 Feb 93) are referred to in the GP notes but no copies of the report are available (and according to transcript of evidence, one of these smears belonged to another patient altogether).

She appeared to be symptomatic for some months prior to diagnosis (11 Mar 97). At the time of the first symptomatic presentation, she did have an atypical smear (4 Oct 96) (which appears to have been reviewed at some point but the documentation is incomplete) but this did not trigger any urgent investigations.

Recognition of abnormalities on the smears prior to diagnosis and to the development of symptoms would most likely have allowed earlier diagnosis prior to its progression to invasive cancer with the need for less radical treatment.

When she did present with symptoms, neither her GP nor her gynaecologist initially recognised her cervical cancer at pelvic examination, attributing the abnormality to cervicitis and thus further delaying the diagnosis by 6 months. At the time of definitive surgery (16 Apr 97), the disease was confined to the cervix and so this subsequent delay of 6 months probably made no difference to her outcome.

PATIENT 5:

This patient had two separate disease processes, dysfunctional uterine bleeding resulting in menorrhagia and CIN 3. A smear in 1991 was reported by Dr Bottrill as normal but was re-read in Sydney as “high-grade”. A further smear in Feb 95 was similarly mis-read. There was a delay in diagnosis of her CIN due to the missed smears, but the pathology was eventually picked up on cervical cytology examined by Medlab Hamilton (24 Apr 98). Appropriate and apparently successful treatment was instituted. There were no apparent consequences from delay.

Although there is a reference to VAIN in the summary attached to the patient's statement of evidence, I was unable to find any reference to this condition in any of the files.

PATIENT 6:

This patient had several miscellaneous problems of no particular relevance to the matters in hand. A smear in March 1991 reported by Dr Bottrill as normal was thought to be "inconclusive – high grade lesion could not be excluded"). Her CIN 2 was eventually detected as a result of review of the Sydney "re-read" and colposcopic investigation of this smear and coincided with a new abnormal smear that was detected during this assessment.

There was possibly a delay in diagnosis due to the missed smear, but it is possible that investigation of the inconclusive smear in 1991 may not have revealed any CIN. Her CIN 2 was eventually detected, with appropriate and apparently successful treatment instituted in Dec 99. There were no apparent consequences from delay.

Five other smears were taken between 1991 and diagnosis in Oct 99 (including one taken the week before diagnosis) and were reported as essentially normal, but these smears were not reviewed (including one reported by Dr Bottrill - 8 Feb 93).

PATIENT 7:

This patient appeared to have two blood stained unsatisfactory smears taken some time (3 and 4 years) prior to diagnosis. Dr Bottrill reported one of these as bloodstained normal, but it has since been reviewed by Medlab Hamilton as showing CIN 3. The other was not reported by Dr Bottrill, but by Gisborne Hospital, and has not been reviewed. She had a very advanced carcinoma of the cervix at presentation in Aug 99 and it is likely that there was an abnormality present at the time of the first smear, which subsequently progressed over the following four years. It seems likely that she suffered considerably from the failure to diagnose at an earlier stage.

There may remain some questions regarding the clinical management at the time of the smears and whether there was a failure to recognise or investigate an abnormality on the cervix, particularly in the presence of a heavily blood stained smear. Although, there is no record in the notes of the patient being symptomatic (apart from bleeding whilst taking the Pap smear) until June 99, it is unclear from the notes as to whether or to what extent the patient was symptomatic.

It is clear however that an opportunity to diagnose this patient's cervical disease at an earlier point was missed.

PATIENT 8:

This patient remained poorly screened despite multiple interactions with gynaecologists and other doctors for her complex medical, obstetric and gynaecological history. Her only apparent smear in August 94 was taken at an inopportune time (post-partum) and was reported by Dr Bottrill as normal. This was a "high-grade" smear according to the Sydney re-read. Despite other opportunities for screening, no other smears appear to have been taken. The irregular bleeding which occurred prior to and during her pregnancy, that is during the 9-12 months prior to diagnosis, was in retrospect inaccurately attributed to pregnancy complications and no other consideration seemed to be given to the possibility of cervical pathology. I note her verbal evidence that her doctors were concerned not to disturb the pregnancy. At eventual diagnosis, the cancer was clearly far advanced. It is likely that earlier diagnosis by either the correct reading of the smear in August 94, by more frequent opportunistic screening or by more astute clinical judgement would have detected the cancer at an earlier and more treatable point.

PATIENT 9:

This patient had three regular smears in 1988, 1991 and 1993, which were reported as normal by Dr Bottrill. The first was not reviewed. The second was reported on the Sydney re-read as "inconclusive – high grade lesion cannot be excluded and the third was re-read as "high-grade". She appears to have then developed symptoms and was noted to have a somewhat abnormal cervix for about six months prior to the eventual diagnosis of advanced cervical cancer in May 1997.

There is no way of telling what the stage of disease was in September 96 when a smear was examined at Gisborne Hospital (read as normal with "scant squamous cells - no evidence of cellular abnormality") (this smear was not reviewed). There were some symptoms at this time and it is likely that there was invasive cancer present.

It appears that her disease could have been diagnosed earlier with accurate reporting of her smears and earlier assessment of her symptoms (although the disease was probably well advanced by the time it was symptomatic compared to the period from the first abnormal smear).

14. Although I have not reviewed their files in the same detail, I am also aware of the evidence of another 10 patients (patient numbers 11 - 20) who have given similar accounts. The general thrust of the evidence from these patients has confirmed the impressions I gained from detailed review of the records of the first 9 patients.

GENERAL COMMENTS

15. Review of these cases has given me an impression of the situation in relation to cervical screening in the Gisborne area during this time, with a particular opportunity to see some of the end stage consequences of failed cervical screening. Although I recognise that it is only a small sample of the total population of the women of Gisborne, it did seem to contain a larger number of mis-reads, and particularly a larger number of repeated mis-reads, than one would expect to find in such a group. The overall impression gained is a sense that this is an effectively unscreened population of women who are presenting with the range of cancers typical of an unscreened population. In this context, I would like to make several general comments in relation to these cases.

16. Cervical screening is a pathway of clinical encounters, which must function effectively to gain maximum benefits for the population being screened. The pathway includes recruitment of women to the screening program, the taking of an adequate smear, the correct laboratory interpretation of this smear, the notification of results to the woman and the correct clinical management of women with screen-detected abnormalities. All steps in this pathway must function correctly for the system to work. With each step being essentially a clinical encounter dependent on human involvement, there is a potential for error at any point. The more significant the number or nature of the errors, the more substantial the total error for the system. Cervical screening "systems" allow for this potential error by encouraging women to undergo regular repeated screening and by the application of quality systems at each point of encounter with the system. Screening registers which have been established in many countries are designed to help recruit women to screening and to ensure that they have regular smears. The nature of cervical cancer with its relatively long preclinical phase, before progression to invasive symptomatic cancer allows for the detection of preinvasive disease, usually several years before the disease becomes symptomatic.

17. Taking the smear, interpreting the smear and management of the abnormalities is dependent on a clinical encounter and therefore always potentially subject to error. In laboratory terms this is the false negative rate that is always assumed to exist with cytologic interpretation of Pap smears. However high the quality standards in any particular laboratory may be, because of the very nature of screening there is always going to be the possibility of mis-read smears. Screening programs account for this possibility by encouraging women to undergo repeated screening at regular intervals, on the statistical assumption that it is very unlikely for a rare event to happen to particular woman more than once.

18. In relation to the Gisborne experience, there seems to be a pattern of women who have repeatedly had their smears mis-read. The fact that smears have been taken along the way, and now in retrospect have been found to be abnormal, serves as a documentation of the natural history of the disease in each of these women. Amongst this group of women, I saw a display of the range of clinical behaviour of cervical neoplasia from spontaneous regression in some cases, through to persistent indolent disease and to fatal progressive invasive cancer. The total number of mis-read smears in this group of women, and repeatedly in particular women, suggests that the events were not random misfortune but more suggestive of a pattern of very poor laboratory performance, in which abnormalities were repeatedly not detected.

19. In relation to other aspects of the screening pathway in Gisborne, whilst one in retrospect could be critical of the occasional clinical encounter, there is no consistent pattern of poor clinical behaviour or management seen in relation to these women. In some aspects there are apparent misunderstandings about cervical screening, particularly the difference between preinvasive and invasive disease, suggesting that public education programs about screening have not been as successful as one may have hoped, but these problems are common to many if not all screening programs throughout the world. The overwhelming impression is that these women and their health practitioners thought that they could depend on the screening that was taking place.

20. Although in some cases, the delay in diagnosis seems to have had no major medical consequences, this has tragically not been the case for many others. It is clear that several women have lost the chance to have their cervical pathology diagnosed at a treatable point and gone on to develop advanced and fatal cervical cancer.

AUSTRALIAN SYSTEM

21. The principles of cervical screening and the elements of a functioning cervical screening program have been described in the brief of evidence presented by Professor Euphemia McGoogan. I will not repeat this description but I agree with her general comments about screening programs.

22. Like many countries, Australia has been dealing with the issue of improved cervical screening in an organised manner since the late eighties. In 1991, a national report *Cervical Cancer Screening in Australia: Options for Change* (AHMAC, 1991) was presented to and adopted by Australian Ministers for Health. Following this report a committee was established to examine screening practices in Australia. This committee produced the report *Making the Pap Smear Better* (CDHSH, 1993) which recommended the adoption of a national screening policy, the establishment of an Organised Approach to the Prevention of Cervical Cancer (OAPCC) (which later became the National Cervical Screening Program), including cervical cytology registers and made 37

recommendations about cervical screening, including 11 addressing laboratory operations. I have attached a copy of this report (**GVW/CA/0001**).

23. The National Cervical Screening Program continues to function with a secretariat in the Commonwealth Department of Health and Aged Care, whose primary role is to coordinate national activity and to implement the national screening policy. Funds are provided to each state and territory under the Public Health Outcomes Agreement to supplement their coordinating activities and programs in relation to cervical screening.

24. This includes the maintenance of cervical cytology registers, which are now functioning in all states and territories. The registers provide a record of women's smears, sends reminders to them when they are overdue for follow-up smears or treatment and collects statistics on program performance measures, including quality indicators. Each state register has been established according to a variety of state laws and regulations and there are tight controls on the transfer of information between registers and other bodies designed to protect the privacy of women, providers and laboratories.

25. In NSW, the NSW Pap Test Register (PTR) is managed by the NSW Cancer Council, which also manages the NSW Cancer Registry on behalf of the Department of Health. The PTR has been established under the Public Health Amendment Act 1996 and requires laboratories to report all Pap tests, including the names and details of the women and her results, to the register. Monitoring of the program and the production of summary reports are performed by the NSW Cervical Screening Program (NSW CSP). I have attached a copy of the most recent *Annual Statistical Report* of the Program (**GVW/CA/0002**).

26. Funds for the provision of clinical services and for the laboratory processing of smears are provided directly through the Medicare funding arrangements from the Commonwealth Department of Health.

27. The NSW Cervical Screening Program (NSW CSP) has been managed by the Western Sydney Area Health Service (WSAHS) under a Performance and Funding Agreement between the NSW Department of Health and WSAHS since 1996. The program is contracted to promote the National screening policy, to reach a number of outcome targets and performance measures, including the recruitment of unscreened women to the program and to provide reports to the Department of Health on a number of aspects of the Program's performance. I have included a copy of the schedules attached to the contract which detail these targets and other requirements (**GVW/CA/0003**).

28. The Program is funded to carry out a coordinating role for cervical screening in NSW and has recently published an endorsed strategic plan for cervical screening in NSW for the next five years. I have included a copy of this plan to give an outline of the range of activities and targets for the program (**GVW/CA/0004**).

29. The issue of laboratory accreditation and quality assurance has been the subject of ongoing attention and enhancement since the early nineties. To obtain reimbursement for the processing of Pap smears, a laboratory has always needed to be accredited by the National Association of Testing Authorities (NATA). To be accredited by NATA for Gynaecological Cytology a laboratory must be enrolled in, participate in and remain actively involved in both internal quality assurance (QA) and an external quality assurance program complying with criteria set by the National Pathology Accreditation Advisory Council (NPAAC) and meet the requirements for gynaecological cytology which are set out in the document *Requirements for Gynaecological(Cervical) Cytology* (NPAAC, 1997). I have attached a copy of this document (**GVW/CA/0005**). These requirements became compulsory in July 1999. Laboratories are inspected, assessed and registered by NATA, in association with the Royal College of Pathologists of Australasia (RCPA), on a three yearly basis.

30. If a laboratory is inspected and found not to comply with the requirements, a quality improvement process will be initiated by NATA/RCPA. As the only participants are NATA and the RCPA, I am not personally aware of this having taken place nor am I aware of the details of such a process. If the laboratory after some time fails to comply, NATA may notify the Health Insurance Commission and Medicare payments may be withheld, although again I am not aware that this has ever happened in practice.

31. Internal QA systems are assessed as part of the external quality assurance process. The accreditation process refers to NPAAC guidelines which provide two standards related to internal QA:

    - Each laboratory must possess documentation of its internal quality control which covers all of its activities
    - There must be a documented system of follow-up for correlating the results of gynaecological cytology with relevant histopathology.

    These standards are general recommendations, which are not specific or restrictive.

14. The only external quality assurance program available in Australia is that run by the Quality Assurance Program (QAP) of the RCPA, which has been developed in consultation with the

Quality Assurance, Scientific and Education Committee of the RCPA, and a number of professional bodies and associations. Programs exist for eight pathology disciplines including Cytopathology.

15. Since 1988 the RCPA Cytopathology external QA Program has been available. Laboratory participation was originally voluntary. For a fee laboratories were issued with an annual, six slide survey which was selected by an expert panel. The expert panel considered a satisfactory result was one that would not adversely affect patient management.

16. In accordance with recommendations made in Making the Pap Smear Better, the RCPA expanded and strengthened the program. In 1996, the National Cervical Screening Program finalised national performance standards and standardised the smear reporting format and terminology. These became requirements in 1997 and are summarised in the document *Requirements for Gynaecological (Cervical) Cytology* (NPAAC, 1997). They include an assessment of the laboratory's performance against a set of performance standards which make up the *Performance Standards for Australian Laboratories Reporting Cervical Cytology* (CDHFS, 1996). I have also attached a copy of this document (**GVW/CA/0006**). Inspections taking place after 1 July 1999 include a compulsory assessment of the laboratory's performance. The RCPA QAP collects performance data annually and provides each laboratory with a report of its performance and this report is used in the NATA/RCPA inspection process. Cervical cytology registries (including the NSW PTR) are able to assist in this process by providing most of the necessary data to laboratories for completion of the RCPA QAP data collection forms.

17. The entire process is confidential with no identifiable information about any individual laboratory's performance being known to any body or person other than the laboratory, the RCPA QAP and NATA. The RCPA QAP publishes an annual report summarising the data submitted by Australian laboratories reporting cervical cytology, based on the self-reported data submitted by individual laboratories. I have attached a copy of the most recent report for 1998 (**GVW/CA/0007**).

18. Consensus *Guidelines for the Management of Women with Screen-detected Abnormalities* were adopted and endorsed by the National Health and Medical Research Council in 1994. I have included a copy of this document (**GVW/CA/0008**). These have become the basis for standard management of women with screen-detected abnormalities and appear to have been generally adopted by clinicians, although there has been no formal evaluation of their impact on clinical practice.

Gerard Vincent Wain

Dated:

APPENDIX 1:

CURRICULUM VITAE

A. PERSONAL DETAILS

Name: Gerard Wain

Business Address: Department of Gynaecological Oncology,
Westmead Hospital,
WESTMEAD, NSW 2145
AUSTRALIA

B. EDUCATION

High School:

1965-70: St. Bede's College, Mentone, Victoria

University Education:

1975-80: Monash University, Melbourne.
Attended Prince Henry's Hospital Clinical School.
Graduated with MB.BS degree in December 1980.

Internship and Residency:

1981: Prince Henry's Hospital, Melbourne
1982: Junior Resident Surgical Officer.
Prince Henry's Hospital, Melbourne.
1983-84: Resident Medical Officer in Obstetrics and Gynaecology.
The Royal Women's Hospital, Melbourne.
1985: Registrar in Obstetrics and Gynaecology.
The Royal Women's Hospital, Melbourne.

C. APPOINTMENTS

1986-87: Registrar in Obstetrics and Gynaecology.
Royal Devon and Exeter Hospital,
Exeter, United Kingdom.

1987-88: Fellow in Gynecologic Oncology,
University of Southern California,
Los Angeles, California, U.S.A.

1988-89: Senior Registrar in Gynaecological Oncology,
Royal Adelaide Hospital, Adelaide.

1989-90: Fellow in Gynaecological Oncology
Royal Hospital for Women, Paddington, NSW

1990-94: Staff Specialist in Gynaecological Oncology,
Royal Hospital for Women, Paddington, NSW

1990-94: Lecturer in Gynaecological Oncology
University of NSW

1990-94: Accredited Visiting Medical Specialist,

Prince of Wales/Prince Henry Hospitals, Randwick, NSW

D. CURRENT APPOINTMENTS

1994- Director and Senior Staff Specialist
Gynaecological Oncology Unit
Westmead Hospital, Westmead, NSW

1994- Senior Lecturer in Gynaecological Oncology
Department of Obstetrics and Gynaecology
University of Sydney, NSW

1996- Director of NSW Cervical Screening Program

E. PROFESSIONAL QUALIFICATIONS

Fellow of the Royal Australian College of Obstetricians and Gynaecologists (1988) (FRACOG)

Certificate of Gynaecological Oncology of the Royal Australian College of Obstetricians and Gynaecologists (1990) (CGO)

F. PROFESSIONAL ASSOCIATIONS

International Gynecologic Cancer Society
Australian Society of Gynaecological Oncologists
Clinical Oncology Society of Australia
Australian Medical Association
Australian Society of Colposcopy and Cervical Pathology

G. COMMITTEES

Oncology Advisory Committee
University of NSW (1990-94)

Professional Education and Training Committee
NSW Cancer Council (1991-96)

Committee for the Teaching of Ethics
Medical Faculty, University of NSW (1991-94)

Pap Smear Working Party
Eastern Sydney Area Health Service (1993-94)

Recruitment Sub-Committee, Cervical Cancer Task Force
NSW Cancer Council (1993-94)

Health Outcomes Council
Western Sydney Area Health Service (1994-7)

NSW Pap Test Register Management Committee
NSW Cancer Council (1994-)

Gynaecological Oncology Study Group
Secretary (1990-)

National Advisory Committee, National Cervical Screening Program,Dept of Health and Family Services, Canberra (1996-8)

State Advisory Committee, NSW Cervical Screening Program
NSW Dept of Health (1996-)

Policy and Cost Effectiveness Working Party
National Advisory Committee, National Cervical Screening Program,
Dept of Health and Family Services, Canberra (1998-)

NSW State Committee, RANZCOG (1999-)

H. THESIS FOR CERTIFICATE OF GYNAECOLOGICAL ONCOLOGY

"Cervical Cancer Screening: An Analysis of Failures", submitted as part of requirements for CGO, RACOG, Melbourne, November 1990.

I. PRESENTATIONS

"Glomerulonephritis and Pregnancy". Presented to the Quarterly Scientific Meeting of the Victorian Branch of the Royal Australian College of Obstetricians and Gynaecologists, Melbourne. November, 1985.

"Recurrent Germ Cell Tumors". Presented at the Joint Meeting of the Australian and Canadian Societies of Gynaecologic Oncology, Toronto. October, 1989.

"Surgical Resection of Involved Lymph Nodes in Advanced Cervical Cancer". Presented at the Annual Scientific Meeting, COSA, Melbourne. November, 1990.

"Pitfalls in Diagnosis of Cervical Cancer" and "Bowel and Urinary Tract Injuries in Gynaecological Surgery". Invited presentations at "Gynaecological Oncology for the Generalist", at Leura. April, 1991.

"Cervical cancer after negative Pap smears: Rapid-Onset Cervical Cancer". Presented at Scientific Meeting of the International Gynecologic Cancer Society, Cairns, September, 1991.

"Ultrasound: The Gynecologic Oncologist's Perspective". Presented at the Annual Scientific Meeting of the Australian Society for Ultrasound in Medicine, Sydney, November 1991.

"Medicolegal Problems in Gynaecologic Oncology". Presented at Medico-Legal Problems in Obstetrics and Gynaecology Symposium, Sydney, November, 1991.

"The Pap smear histories of 237 women with cervical cancer". Presented at the Annual Scientific Meeting of Clinical Oncology Society of Australia, Sydney, December 1991.

"Problems in Screening and early diagnosis of Cervical cancer". Invited speaker at the Annual meeting of the Fijian Medical Association, Suva, September 1992.

"Problems with Pap smear screening". Invited presentation at "Update in Gynaecological Oncology", at Leura. April, 1993.

"Surgery in the management of uterine sarcomas". Presented at Uterine Sarcoma Workshop, International Gynecologic Cancer Society, Stockholm, September 1993.

“Outcomes Assessment in Gynaecological Cancer Care - Is it important?”

Presented at Workshop in Gynaecological Cancer Care, Parramatta, November 1994.

“A workshop approach to Outcomes assessment in gynaecological cancer care.” Presented at First Health Outcomes Projects Feedback Workshop, Sydney, 4 May 1995.

“Integrating Quality of Life measurement into gynaecological cancer outcome assessment”. Presented at COSA Mid-year Meeting on Quality of Life in Cancer, Alice Springs, July 1995.

"Gynaecological care of women with abnormal Pap smears: how varied is current practice?" Presented at Annual Scientific Meeting, Royal Australian College of Obstetricians and Gynaecologists. Perth, Sept 1995.

“Outcome assessment in gynaecological cancer care”. Presented at Annual Scientific Meeting, Australian Society of Gynaecological Oncologists. Fremantle, September 1995.

“How to avoid litigation in cervical screening.” Presented at Medicolegal Symposium, Carlton-Crest Hotel Melbourne, 11-12 Dec 1996.

“Medicolegal issues in Pap smear screening”. Presented at symposium: Medicolegal Issues in Women’s and Child Health Practices. Liverpool Health Service, 22 Feb 1997

“Information Needs of Gynaecological Cancer Patients: Who wants to know?” Presented at Annual Scientific Meeting, Australian Society of Gynaecological Oncologists. Tasmania, April 1998

“Legal Issues in Cervical Cancer Screening”. Presented at 1998 Medico-Legal Conference. Sydney, September 1998.

“Screening Programs - Where to Beyond 2000?”. Invited speaker at Annual Scientific Meeting, Australian Society of Colposcopy and Cervical Pathology. Noosa, April 1999.

“Variations in cervical cancer screening by socio-economic, region, migrant and aboriginal status in NSW women”. Presented at Annual Scientific Meeting, Australian Society of Gynaecological Oncologists. Queenstown, New Zealand, April 1999.

“Recent advances in cancer care: why do we need to be cautious?” Invited speaker at symposium, “The role of operative laparoscopy in the management of gynaecological malignancies”. St George Private Hospital, Kogarah, April 1999.

J. PUBLICATIONS

PEER-REVIEW JOURNAL ARTICLES:

1. Wain GV, Farnsworth A and Hacker NF. "The Pap smear histories of 237 patients with cervical cancer". Med J Aust, 1992, 157:14-16.

2. Wain GV, Farnsworth A, and Hacker NF. "Cervical cancer after negative Pap smears: Evidence against Rapid-onset cancers". In J Gyn Cancer, 1992, 2: 318-323.

3. Ward J and Wain GV. "Increasing response rates by gynaecologists to a survey: a randomized trial of telephone prompts." Aust J Pub Health, 1994,

18:332-334.

4. Ward J and Wain GV. "Gynaecologists and public health: type frequency and effectiveness of smoking cessation advice provided to smokers with abnormal Pap smears." Health Promotion J Aust, 1995, 5:37-40.

5. Nicklin JL, van Eijkeren M, Athanasatos P, Wain GV and Hacker NF . "A comparison of ovarian cyst aspirate cytology and histology: The case against aspiration of cystic pelvic masses." Aust NZ J Obstet Gyn, 1994, 34:546-549.

6. Van der Velden J, Gitsch G, Wain GV, Friedlander ML and Hacker NF. "Tamoxifen in patients with advanced epithelial ovarian cancer." Int J Gyn Cancer, 1995, 5:301-305.

7. Woo WH, Millard RJ and Wain GV. "Bilateral ureteric obstruction from pelvic endometriosis." Int Urogyn J, 1994

8. Wain GV, Ward J and Long D. "Characteristics of women treated for cervical cancer at Westmead Hospital: Implications for hospitals and community-based health services." Australian Health Review, September 1995, 18:111-117

9. Hacker NF, Wain GV and Nicklin JL. "Resection of bulky, positive lymph nodes in patients with cervical carcinoma." In J Gyn Cancer, 1995, 5:250-256.

10. Wain GV, Ward J and Towler B. "Gynaecological care of women with abnormal Pap smears: how varied is current practice?" Med J Aust, 1995, 162:348-353.

11. Gitsch G, Friedlander ML, Wain GV and Hacker NF. “Uterine papillary serous carcinoma. A clinical study.” Cancer, 1995, 75:2239-43

12. Taylor R, Bell J, Coates M, Churches T and Wain G. “Cervical cancer in NSW women: five year survival 1972-1991". Aust J Public Health, 1996, 20(4):413-20.

13. Wain GV. “Cervical cancer screening in Australia: Let’s keep it in perspective.” MJA, 1996, 164:261-2.

14. Wain GV. “Automation in cervical cytology: whose cost and whose benefit?” MJA, 1997, 167:460-461.

15. Hahlin M, Jaworski RC, Wain GV, Harnett PR, Neesham D and Bull C. “Integrated Multimodality therapy for embryonal rhabdomyosarcoma of the lower genital tract in postpubertal females”. Gynecologic Oncology 1998, 70:141-146.

16. Rieger E, Touyz SW and Wain GV. “The role of the clinical psychologist in gynaecological cancer.” Journal of Psychosomatic Research 1998, 45:201-214.

17. Manolitsas T, Biankin S, Jaworski R and Wain GV. “Vulval squamous cell carcinoma arising in chronic hidradenitis supporativa”. Gyn Oncology 1999, 75:285-288.

NON PEER-REVIEW JOURNAL ARTICLES:

1. Wain GV and Hacker NF. "Pitfalls in Screening and Diagnosis of Early

Cervical Cancer". Current Opinion in Obstetrics and Gynaecology, 1990, Volume 2:74-79.

2. Wain GV. "Adenocarcinoma-in-situ of the Cervix". RACOG Continuing Education Resource Manual, Melbourne. Number 79, August 1991.

3. Wain GV. "Current management of ovarian cancer." Current Therapeutics, August 1995.

BOOK CHAPTERS:

1. Wain G and Morrow CP. "Surgical Management of Endometrial Carcinoma", in Gynecologic Oncology IV: Endometrial Carcinoma. Eds. Alberts DS and Surwit EA. Martines Nijhoff, Boston, 1988.

2. Hacker NF, Wain GV and Trimbos JB. "Management and Outcome of Stage III Epithelial Ovarian Cancer". Proceedings of Helene Harris Memorial Symposium. Charleston, April 1991.

3. Wain GV and Hacker NF. "Genital Sarcomas", in Surgical Gynecologic Oncology. Eds Burghardt E, Kindermann G, Monaghan J and Webb M, Georg Thieme Verlag, Stuttgart, 1993.

4. Wain GV and Hacker NF. "Multimodality therapy for vulvar and vaginal cancer." in "Multimodality therapy in Gynecologic Cancer. Eds. Knapstein PG and Sevin BU. Georg Thieme Verlag, Stuttgart, 1996.

PUBLISHED ABSTRACTS:

1. Hacker NF, Wain GV and Nicklin J. "Resection of Bulky Positive Lymph Nodes in Cervical Cancer" (abstract). Int J Gyn Cancer, 1993, 3 (Supp 1), 2.

2. Favalli G, Berg D, Wain GV and Hacker NF. "Morbidity associated with Extended Field Chemoradiation for Locally Advanced Cervical Cancer" (abstract). Int J Gyn Cancer, 1993, 3 (Supp 1), 11.

3. Wain GV, Friedlander M, Jensen D and Truskett P. "Placental Site Trophoblastic Tumour - An Enigmatic Disease: Two case reports" (abstract). Int J Gyn Cancer, 1993, 3 (Supp 1), 47.

4. Wain GV, Nicklin J and Hacker NF. "Surgery in the management of uterine sarcomas" (abstract). Int J Gyn Cancer, 1993, 3 (Supp 1), 56.

5. Wain G, Ward J, Barton M, Shiell A and Dewar R. "Multidimensional outcomes assessment in gynaecological cancer care". Int J Gyn Cancer, 1995,

K. RESEARCH GRANTS

1. Ward J and Wain GV. "Evaluation of Doctor's Reminders in Casualty to Encourage Pap smears". NHMRC - PHRDC. (1994 - $35188 and 1995 - $35388)

2. Wain G, Ward J, Barton M, Shiell A and Dewar R. "A workshop approach to outcomes assessment in gynaecological cancer care". NSW Health Department 1994 ($49,600)

3. Ward J, Wain GV, Gordon J and Christmas H. "Development and controlled evaluation of an undergraduate intervention to enhance students' knowledge, skills and attitudes in cervical cancer prevention." NSW Cancer Council 1994 ($96,618)

4. Ward J, Yoong L, Wain GV and Mira M. “Comprehensive Pap smear screening project for GPs in Central and Western Sydney”. Department of Health and Human Services, Canberra, Divisions and Project Grants Funding 1995-6 ($249,000)

5. Wain GV, Ward J, Barton M, Shiell A and Dewar R. "A workshop approach to outcomes assessment in gynaecological cancer care: II. Development and Application of Clinical Practice Guidelines and Best Practice Indicators". NSW Health Department 1995 ($51,100)

6. Wain GV, Hunt B and Maher L. “Development of patient satisfaction and quality of care instrument”. WSAHS Health Outcomes Council 1995 ($6,000)

7. NSW Cervical Screening Program. “Development of computer software for recruitment to cervical screening”. Public Health Funding Agreement Incentives Projects. Commonwealth Department of Health and Aged Care 1998 ($130,000).

8. NSW Cervical Screening Program. “Hospital Derived Cervical Cancer Registry Pilot Project”. Public Health Funding Agreement Incentives Projects. Commonwealth Department of Health and Aged Care 1998 ($85,000).

L. TEACHING RESOURCES DEVELOPED

1. “Preventing cancer of the cervix: An overview for medical students”. An educational video and teaching notes. NSW Cervical Screening Program, 1997.

2. “Preventing cancer of the cervix: An overview for general practitioners”. An educational package including video, trigger videos, facilitator and participant workbooks. NSW Cervical Screening Program, 1998.

3. “Do I really need a Pap Test?” An educational video for women. NSW Cervical Screening Program, 1997.

M. TEACHING COMMITMENTS:

Gynaecological oncology component of Fifth year medical undergraduate class, Western Clinical School, University of Sydney.

Supervisor of Postgraduate training in Gynaecological Oncology Fellowship Program at Westmead Hospital, accredited by the Royal Australian College of Obstetricians and Gynaecologists.

Teaching “Overview of Gynaecological Cancer” in Oncology Nursing Course, NSW College of Nursing.

Chair, Cancer Block Committee and Problem Coordinator “Cervical Cancer” in Graduate Medical Program, University of Sydney.

Invited speaker at “General Practice Health Care for Women Workshop”, conducted by the Royal Australian College of General Practitioners, NSW Faculty, May 1994-99.

Key speaker at “Preventing cancer of the cervix: An overview for general practitioners”. An educational package presented at 35 Divisions of General Practice in NSW throughout 1998.